

Oregon Community Unit School District #220

206 South Tenth Street, Oregon, Illinois 61061

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Consent for Administration of Prescription Medication

Oregon C.U.S.D. #220 School Policy states that medications may be given to students *only upon written prescription of a physician and the written request of a parent/guardian*. It also states that students may participate in self administration of medications. All information is kept confidential, and will become a permanent part of your child's health record.

STUDENT NAME: _____ BIRTHDATE: _____

SCHOOL: _____ GRADE: _____ TEACHER: _____

PARENT REQUEST SECTION:

As the parent or legal guardian of the above named student, I hereby request that the school nurse or other authorized school personnel give the prescription or medication as designated below.

****Parent Signature:** _____ **Phone:** _____ **Date:** _____

TO SEND MEDICATION TO SCHOOL:

1. The prescription-labeled or original medication container must be sent.
2. On the medication container must be written the student's name, doctor's name, date, medication, dosage and the time to be given.
3. All medications will be kept in the school office unless we receive a doctor's order for your child to carry it with him.
(Example: epi-pen)

PHYSICIAN REQUEST SECTION:

Medication Name: _____

Amount to be Given: _____

Time/Times to be Given: _____

Start Date: _____ Discontinue Date: _____ Re-Eval. Date: _____

Diagnosis Requiring Medication: _____

Expected Side Effects, if any: _____

Dosage & Times Given at Home: _____

Other Medications Child Takes: _____

Approval for student to carry emergency medication (Inhaler/Epi-pen/insulin) YES NO (Recommend age 10 years and over only)

I hereby request that the school nurse or other authorized school personnel give the prescription designated above, as it is medically necessary for dose(s) to be given during school hours.

Physician's Name: _____ Physician's Signature: _____ Date: _____

Physician's Address: _____ Phone: _____ Fax: _____

School Nurse Signature _____ Date _____